



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
**SECOND INJURY FUND SURCHARGE
FIRST QUARTER**

1st Quarter 2003
January 1, 2003 - March 31, 2003
**(Delinquent and Penalty due
if received after
April 30, 2003)**

Commercial Insurance Carriers
(Please submit a separate form for each company.)

Company Name and Address:

NAIC # _____ FEIN # _____

If there has been a name or ownership change in the past 24 months please indicate previous name(s) or owner(s):

Date this form will be sent: _____

Parent Company or Group Name and Address:

NAIC # _____ FEIN # _____

NAIC # _____ FEIN # _____

THE DATE ABOVE MUST BE ENTERED IN ORDER FOR AMOUNTS TO CALCULATE CORRECTLY.

1. New or renewed gross premiums for policies with 2003 inception dates	\$ _____
Returned or refunded premiums for policies with 2003 inception dates	- \$ _____
Net Premium	= \$ _____
a. Multiply by 2003 Surcharge Assessment (4.0%)	= _____
New, renewal or additional gross premiums for policies with 2002 inception dates	\$ _____
Returned or refunded premiums for policies with 2002 inception dates	- \$ _____
Net Premium	= \$ _____
b. Multiply by 2002 Surcharge Assessment (2.5%)	= _____
Additional gross premiums collected for policies with 2001 and prior inception dates	\$ _____
Returned or refunded premiums for policies with 2001 and prior inception dates	- \$ _____
Net Premium	= \$ _____
c. Multiply by 2001 Surcharge Assessment (2.5%)	= _____
2. Total lines 1a, b, & c = Total Missouri Second Injury Fund Surcharge Due:	_____
3. If received by the Division after April 30, 2003, the payment is delinquent. Continue completing this form.	
a. Enter amount shown in Item 2 (Total lines a, b, & c)	\$ _____
b. Late penalty, which is the Surcharge Assessment Subtotal x 0.5%	+ \$ _____
c. Interest, which is the Surcharge Assessment Subtotal x 1.5% x _____ (number of months or any fraction of a month delinquent)	+ \$ _____
4. Add lines 3a, b, & c = Total Missouri Second Injury Fund Surcharge w/ Penalty & Interest Due:	_____

Name of person completing form	E-mail Address	Phone Number	Date
I hereby certify that this application contains no willful misrepresentation or falsifications and that the information provided is true and complete to the best of my knowledge and belief.			
Signature - Pres./Exec. Officer	Printed Name	Title	Date

Mail one copy of this form and a check made payable to:
Missouri Division of Workers' Compensation, Attn: Second Injury Fund, P.O. Box 58, Jefferson City, MO 65102-0058
(Mail this copy even if no money is due at this time.)

Keep one copy for records.

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